Appendix A

Plan

identifier "HCC7-Plan1"

effective-date "01-01-2000 12:00 AM"
expiration-date "01-01-2002 12:00 AM"

Exclusions
//Abortions elective or non-therapeutic except if the abortion is necessary to save the life of the woman
//*Medically necessary to save the woman's life - this requires a set of ICD-9 codes to identify the need for the abortion
Not Covered: member service-category"Abortion" service "59812", "59840", "59841", "59850", "59851", "59855", "59856", "59100", "59852", "59857

//Altered gender characteristics
Not Covered: member service-category"sex change" service "55980", "55970"

//*Alternative thearapies, acupuncture (except when used as an anesthetic during surgery and when administered by a providing
//other than the surgey) and acupressure, holistic, homeopathic, naturopathic care, including medications, and ecological or environmental me
Not Covered: member service-category"alternative therapies" service "97780","97781"

// Anesthesia - Procedure where a local anesthetic is not given by or under the guidance of a physian
//*This could be done by Practitioner Speciality using Anesthesiology as the filter or other specific specialities to rule
//out practitioners in the mental health field, and medical professionals who are not doctors
Not Covered: member service-category"Unsupervised procedures requiring local anesthesia"

//Blood Products Donated or replaced blood, blood plasma or blood products drawing the storage of your own blood absnce of a scheduled surge:

//Breast Implants
//* We need the diagnosis for brest implarts for cosmetic reasons verses mastectomy - Could not find the diagnosis first time through.
Not Covered: member service-category"Breast Implants" service "19396", "19328","19330", "19340", "19342"

//Cosmetic services, supplies, surgery to alter an abnormal or normal structrue soley to rendeer it more esthetically pleasing
Not Covered: member service-category"reconstructive or cosmetic surgery"rendered for (diagnosis"V50.1", "V50.3", "V50.41", "V50.0", "701.4)"
Not Covered: member service-category"reconstructive or cosmetic surgery"service "15780", "15781", "15782", "15783", "15788",
"15789", "15792", "15793", "15824", "15825", "15826", "15828", "15829", "15831", "15832", "15833", "15834", "15835", "15836",
"15837", "15838", "15839", "15850", "15851", "15852", "15860", "15876", "15877", "15878", "15879", "11300", "11301", "11302",
"11302", "11305", "11306", "11307", "11308", "11310", "11311", "11312", "11313", "11400", "11401", "11402", "11403", "11404",
"11406", "11420", "11421", "11422", "11423", "11424", "11426", "11440", "11441", "11442", "11443", "11444", "11446", "11450",
"11451", "11462", "11463", "11470", "11471", "69300", "30400", "30460", "30462", "19318", "19325", "19318", "19325"

//* Are these part of cosmetic surgery ? 67973 Total eyelid, lower, on stage or first stage 67974 Total eyelid, upper, on stage or first stage

//Complications of Non-Covered Charges
Not Covered: member service-category"**complications as a result of not covered services**"

//Routine Foot Care
//11719 Trimming of nondystrophic nails, any number
Not Covered: member service-category"**foot care**" service **"11719", "11055", "11056", "11057"**

//Family planning
Not Covered: member service-category"**family planning**" rendered for (diagnosis**"V25.41", "V25.1", "V25.02", "V25.01", "V25.0"**
Not Covered: member service-category"**family planning**" service **"58300", "58301", "58321", "58322","58323"**

//marital, family
Not Covered: member service-category"**counseling**"
Not Covered: member service-category"**nutritional counseling**" service **"S9470"**

//More than one device for the same part of the body, same function, spare or alter
Not Covered: member service-category"**multiple devices for the same purpose durable medical equipment**"

//*Non-standard equipment, deluxe, special-ordered
Not Covered: member service-category"**non-standard, deluxe or special-order durable medical equipment**"

//Braces and support devices used primarily for sports activities
//*Codes needed to identify items that meet this criteria - which may be by ICD-9 or service codes
Not Covered: member service-category"**sporting equipment**" service **"A4570"**
Not Covered: member service-category"**sporting equipment**" rendered for (diagnosis**"726.32"**)

//*Repair, replacement, adjustment or maintenance of device due to damage as a result o abuse or misuse
Not Covered: member service-category"**repair durable medical equipment**"
Not Covered: member service-category"**replacement durable medical equipment**"

//Cosmetic items of durable medical equipment
Not Covered: member service-category"**cosmetic durable medical equipment**"

//Convenience items of durable medical equipment
Not Covered: member service-category"**corvenience durable medical equipment**"

//Model upgrades of durable medical equipment
Not Covered: member service-category"**upgrades of durable medical equipment**"

//A drug, device, medical treatment, procedure, or equipment which is experimental or investigational
Not Covered: member service-category"**experimental drugs, devices, medical treatments, procedures or equipment**"

Not Covered: member service-category"**multiple devices for the same purpose durable medical equipment**"

//Non-standard equipment, deluxe, special-ordered
Not Covered: member service-category"**non-standard, deluxe or special-order durable medical equipment**"

//Genetic Testing that is not medically necessary
Not Covered: member service-category"**genetic testing**"

//Services received through Veternan's Administration or any other government agency or program other than Medicaid
Not Covered: member service-category"**Governement Assistance**"

//Hospital charges that began before the effective date
Not Covered: member service-category"**hospital charges prior to effective date**"

//Hospital charges for impatient care that is primarily x-ray, laboratory examinations, diagnostic studies, and physical examination
Not Covered: member service-category"**routine diagnostics**"

//Dental Hospital Charges unless otherwise stated
Not Covered: member service-category"**Dental Hospital Charges**"

//Modification and improvements to home and automobile to accomidate the installation of covered services and supplies
Not Covered: member service-category"**Home and Auto Modifications**"

//Immunizations for Hepatitis B vaccine for high risk work related situations, and other similar vaccines. Immunizations for the purpose of .
//No immunizations are covered for Insured Peerson over 5 years of age.
Not Covered: member service-category"**Immunizations for work and travel**"
Not Covered: member with age >"5" service-category "**Immunizations**"

//Infertility/fertility treatments and drugs unless otherwise specified
Not Covered: member service-category"**Infertility/Fertility**"

//Services beyond the scope of a Provider's license
Not Covered: member service-category"**Outside license scope**"

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//Services to keep the insured person's condition at the level to which it has been restored
Not Covered: member service-category"Maintenance Services"

//Services for Mental Illness except as specifically provided in the certificate
//* difference between Mental Illness and Mental Health Services?
Not Covered: member service-category"Mental Illness"

//Services for Mental Retardation
Not Covered: member service"Mental Illness" rendered for  (diagnosis"317", "318", "318.0", "318.1", "318.2", "319"

//Missed Appointments
Not Covered: member service-category"Missed Appointments"

//Services and Supplies that are not shown as coverd services and supplies in the comprehensive medical benefit
//Service and Supplies received by an insured person that they would not legally be liable for payment in the absense of coverage
//Medication prescrpbed for non-covered charges
Not Covered: member service-category"Non-Covered Services and Supplies"

//Treatment or prevention of illness or injury (including Mental Illness) using treatment procedures, techniques or therapies outside general
Not Covered: member service-category"non-generally accepted heath care practices"

//Services, supplies and medications that are not medically necessary other than Preventive Care benefit
Not Covered: member service-category"Medically unnecessary services and supplies"

//Confinement, treatment service or supply not recommended and approved by a Physician
//Not Covered: member service-category

//Nursing homes/Rest homes or any facility that provides custodial care
Not Covered: member service-category"Rest Homes"

//services and supplies for organ transplants recipeint is not insured
Not Covered: member service-category"Non-insured organ transplant recipeint"

//Ventricular assist devices when used as an artificial heart
Not Covered: member service-category"artificial heart"

//Experimental or investigational transplants
Not Covered: member service-category"experimental/investigational transplants"
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//Non-human or artificial organs and the related implantation services
Not Covered: member service-category"non-human/artificial organs"

//Bone marrow transplanst for human gene therapy
Not Covered: member service-category"Bone Marrow for Human Gene Therapy"

//unless shoes are attached to brace; arch supports, shoe inserts, special orrder appliances
Not Covered: member service-category"Orthotics"

//Medications, supplies purchased over-the-counter
Not Covered: member service-category"over-the-counter items"

Not Covered: member service-category"paternity/gender tests"

//not covered if lack of normal function is due to psychological cause
Not Covered: member service-category"penile implants"

//personal comfort, hygiene or convience items
Not Covered: member service-category"Personal Comfort"

//Exams and tests at the request of a third party
Not Covered: member service-category"Physical/Psychological Exams"

//Pre-existing except what is under "pre-existing conditions limitations"
Not Covered: member service-category"Pre-existing Conditions"

//Private duty nursing not covered
Not Covered: member service-category"Private duty nursing"

//Charges from a private or public school are not covered
Not Covered: member service-category"Private and Public School"

//Prosthetic devices not covered
Not Covered: member service-category"Prosthetic devices"

//Provider Consultations not covered
Not Covered: member service-category"Provider Consultations"
```

//Phychoterapy not covered
Not Covered: member service-category"Phychoterapy"

//Rehabilitive Programs not covered
Not Covered: member service-category"Rehabilitive Programs"

//Routine care not covered in an emergency/Urgent facility
Not Covered: member service-category"Routine care" delivered by classification"Emergency facility", "Urgent facility"

//Smoke Cessation Programs not covered
Not Covered: member service-category"Smoke Cessation Programs"

//Stockings and related items not coevered
Not Covered: member service-category"Stockings", "compression hose", "elastic hose", "leotards", "elbow supports", "knee supports"

//Thermography not covered
Not Covered: member service-category"Thermography"

//Therapies not covered
Not Covered: member service-category"Educational Therapy", "Recreational Therapy", "Art Therapy", "Massage Therapy", "Biofeedback Therapy", "I

//Ambulance - ambulance use for transportation services only
Not Covered: member service"A0306"

//Ambulance not to an emergency not covered
Not Covered: member service-category"Not Emergency Room Delivery by Ambulance"at POS "23"

//Eyeglasses, contact lenses, Eye Surgery
Not Covered: member service-category"Vision services and supplies"

//Vitamins not covered
Not Covered: member service-category"Vitamins"

//Vocational Rehabilitation not covered
Not Covered: member service-category"Vocational Rehabilitation"

//Illness or Injury arising from war, felony or mistermeanors
Not Covered: member service-category"war, felony, criminal misdemeanor"

//Hospital admissions Friday, Saturday, Sunday unless certified weekend admission is medically necessary; weekend stay after operation; accid
Not Covered: member service-category"Weekend Hospital Charges"

//Programs, medical treatment, surgical treatment
Not Covered: member service-category"Weight Control/Reduction Services"

//Reversal of gastric or intestinal bypass, gastric stapling, or other similar procedure
Not Covered: member service-category"Gastric stapling"

//Illness or injury that arises out of or as a result of the work for wages or profit
Not Covered: member service-category"Work Related Treatment"

//Enhanced chiropractic care not covered
Not Covered: member service-category"enhanced chiropractic care"

Limits
//Maximum of 30 days per of mental health service per calendar year
//Combined inpatient and outpatient
//Limited to short-term evaluation or crisis intervention
Limit member to: 30 day(s): in-patient service-category"mental health services"at POS "51", "52" per calendar-year

//Probably should list the service ids or category
//Combined inpatient and outpatient
//Limited to short-term evaluation or crisis intervention
Limit member to: 20 visit(s): out-patient service-category"mental health services"at POS "11", "51", "52" per calendar-year

//Substance Abuse Inpatient - Limit 2 treatment programs per member liftetime
//*Treatment program must be completed in it's entiretly for payment
Limit member to: 2 confinement(s): in-patient service-category"Substance Abuse" rendered for (diagnosis"304.0", "304.1", "304.2", "304.3",
"304.4", "304.5", "304.6", "304.7", "304.8", "304.9", "305.0", "305.1", "305.2", "305.3", "305.4", "305.5", "305.6", "305.7", "305.8", "305.9

//Substance Abuse - Outpatient - Limit 2 treatment programs per member liftetime
//*Treatment program must be completed in it's entiretl\y for payment
Limit member to: 2 confinement(s): out-patient service-category"Substance Abuse" rendered for (diagnosis"304.0", "304.1", "304.2", "304.3",
"304.4", "304.5", "304.6", "304.7", "304.8", "304.9", "305.0", "305.1", "305.2", "305.3", "305.4", "305.5", "305.6", "305.7", "305.8", "305.9

//Preventive Care
//periodic examinations including diagnostic testing and laboratory services

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//appropriate for such examinations from birth through age 5.
//The frequency of these examinations is determined by the age, health status and medical needs
//of the Insured Person, and are generally as follows:

//Newborn through 4 days, one examination
//*Expressed as a fraction of a year changed .010958904 to 1
Limit member with age >="0" and age <="1" to: 1 visit(s) : service"99381", "99391" per lifetime

//Newborn through 4 days, one examination
//*Expressed as a fraction of a year changed .010958904 to 1
Limit member with age >="0" and age <="1" to: 1 visit(s) : service"99381", "99391" per lifetime

//1 month, one examination
//*Expressed as a fraction of a year changed .083333333 to 1
Limit member with age ="1" to: 1 visit(s) : service"99381", "99391" per lifetime

//2 through 6 months, one examination at each 2 month interval
//*Expressed as a fraction of a year changed .16666667 to 1
Limit member with age >="0" and age <="1" to: 1 visit(s) : service"99381", "99391" per  2 month

//9 through 18 months, one examination at each 3 month interval
//*Expressed as a fraction of a year changed .75 to 1 and 1.5 to 2
Limit member with age >="1" and age <="2" to: 1 visit(s) : service"99381", "99391" per 3 month

//2 through 5 years, one examination each year
//*Expressed as a fraction of a year
Limit member with age >="2" and age <="5" to: 1 visit(s) : service"99381", "99391" per year


//annual gynecological examination
Limit member to: 1 visit(s) : service-category"annual gynecological examination"per year
Limit member to: 1 unit(s) : service"88141" per year

//annual "well-man" examination
Limit member to: 1 visit(s) : service-category"well-man examination"per year

//Mammograms
//One baseline mammogram provided to women who are between the ages of 35 and 39.
Limit member with gender ="Female" and age >="35" and  age <="39" to: 1 visit(s) : service"76092" per lifetime
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//One mammogram every two years provided to women who are between the ages of 40 and 49,
//*or more frequently if recommended by a Physician
Limit member with gender ="Female" and age >= "40"and  age <= "49" to: 1 visit(s) : service "76092" per 2 year

//One mammogram every year provided to women who are age 50 or older
Limit member with gender ="Female" and age >= "50" to: 1 visit(s) : service "76092" per 1 year
//Service 76902 is a screening mammogram.

//One or more mammograms every year for a woman considered "at risk", if recommended by a Physician.
//*Need to determine policy for "at risk"


Benefit Schedule
For In-Network Services Rendered By supplier-network"AZPHC"
//Utilizing PHC Provider Regardless of Where Participant Resides

Benefits:

Exclusions
//Enhanced chiropractic care not covered
Not Covered: member service-category"enhanced chiropractic care"

//Limits
//Substance abuse services
//Inpatient/outpatient are combined benefit
//*In-patient.  No charge.  Limited to to two treatment programs per member per lifetime
//*Out-patient.  No charge.  Limited to to two treatment programs per member per lifetime

//*Outpatient prescription drugs up to 31-day supply

//*Mail Order prescription drugs up to 93-day supply

//Maximum Expenditures
//*Limited to stated copayments
//*Too vague to represent in this version.

Deductibles
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member deductible is: $0.00 includes covered payment co-insurance payment per calendar-year

//office visits Primary Care Physician $15 copayment per visit
Benefit service "99201", "99202", "99203",
"99204", "99205", "99211", "99212", "99213", "99214", "99215" 100 of service cost co-pay $15.00

//office visits - Specialist $25 copayment per visit.
//*What if a specialist is also the PCP? How are we going to distinguish the two?
Benefit service-category "office visit" rendered by specialty "Medical Specialty" 100 of service cost co-pay $25.00

//Emergency room services requires $50 copay (waived if admitted
Benefit member service-category "emergency room services" 100 of service cost co-pay $50.00
Waive co-pay if admitted from emergency room

//Urgent care - $25 copayment at affiliated urgent care center. If Provider does not receive Prior Certification for treatment
//The insured person is required to receive Prior Certification as soon as medically possible. Facility can not be used for routine care
//*How can we distinquish what is urgent care?
//urgent care co-pay $25 if not authorized, Insured pays 100 %

//Ambulance service - no charge, specifically the transportation - not the services done in the transportation right? POS for ambulance are
Benefit member service-category "ambulance" service "A0021", "A0030", "A0040", "A0050", "A0080", "A0090", "A0100", "A0110", "A0120" , "A0130",
"A0210", "A0225", "A0300", "A0302", "A0304", "A0306", "A0308", "A0310", "A0320", "A0322", "A0324", "A0326", "A0328", "A0330", "A0340", "A0342"
"A0366", "A0370", "A0380", "A0382", "A0384", "A0390", "A0392", "A0394", "A0396", "A0398", "A0420", "A0422", "A0424", "A0888", "A0999" 100 of ser
// This includes all ambulance services in the HCPCS Level 2 2000 book.

Benefit member service-category "skilled nursing facility" 100% of service cost requires authorization if not authorized, the penalty is 50.00 %

//Hospice care - requires a referral and certain diagnosis codes which are not specified in the plan
// POS 34
Benefit member service-category "hospice care" at POS "34" 100 % of service cost requires authorization if not authorized, the penalty is 50.00

//Home health care part-time and intermittent skilled nursing care 100% if referral, otherwise 50%
Benefit member service "99315", "99316", "99321", "99322", "99323", "99331", "99332", "99333" 100 of service cost requires referral if not auth
//Service codes refer to domiciliary skilled nursing care, not sure how to specify part-time

//Infertility services 50 % of service cost requires referral, if not authorized, the penalty is 50 % reduction in benefit Only covers diagn
Benefit member service-category "infertility" 50 % of service cost requires referral if not authorized, the penalty is 50.00 % reduction in benef

// Tubal ligations copayment will correspond to the charge associated with the facility in which services were received. POS 11 = Office, POS

// Services listed are under tubal ligation. does tubal ligation with ceasarean delivery count? 58611 What about services that may be need
Benefit member service-category"**Family Planning-Tubal ligations**"service "58600", "58670" at POS "11" 100 % of service cost co-pay $15.00
Benefit member service-category"**Family Planning-Tubal ligations**"service "58600", "58670" at POS "21" 100 % of service cost co-pay $50.00

// Vasectomy copayment will correspond to the charge associated with the facility in which services were received. POS 11 = Office, POS 21 =
// Services listed are under vasectomy. What about services that may be needed as a result of or in preparation for the vasectomy? I did not
Benefit member service-category"**Family Planning-Vasectomy**"service "55250", "52648", "52601", "52648", "55200", "55300", "55400at POS "11" 100
Benefit member service-category"**Family Planning-Vasectomy**"service "55250", "52648", "52601", "52648", "55200", "55300", "55400at POS "21" 100

//*Mental health services: outpatient $20 co-pay per visit individual therapy, $10 co-pay per visit for group therapy
Benefit member out-patient service-category"**mental health - individual therapy**" 100% of service cost co-pay $10.00
Benefit member out-patient service-category"**mental health - group therapy**" 100% of service cost co-pay $20.00

//Corrective appliances and durable medical equipment
Benefit member service-category"**Corrective Appliances DME**" 100 of service cost

//Urgent care services is $25 copayment at affiliated urgent care centers
Benefit member service-category"**urgent care**" 100% of service cost co-pay $25.00

//Inpatient hospital services including physician and facility charges
Benefit member in-patient service-category"**inpatient hosptital services**" 100 of service cost requires authorization if not authorized the pena

//Outpatient hospital services/ambulator surgical center services, authorization is required
Benefit member out-patient service-category"**outpatient hosptital services**" 100 of service cost requires authorization if not authorized the pe

//Laboratory tests and x-rays (office visit copayment may apply for services received in physicians office)
Benefit member service-category"**laboratory tests and x-rays**" 100 of service cost requires authorization if not authorized the penalty is 50.00

//Routine Physicals
Benefit member service-category"**routine physicals** " service "99201", "99202", "99203",
"99204", "99205", "99211", "99212", "99213", "99214", "99215rendered by specialty"**Member's PCP**" 100% of service cost co-pay $15.00
Benefit member service-category"**routine physicals** " service "99201", "99202", "99203",
"99204", "99205", "99211", "99212", "99213", "99214", "99215rendered by specialty"**Medical specialist**" 100% of service cost co-pay $25.00

//Infertility services - diagnosis only
Benefit member service-category"**infertility services**" 50% of service cost requires authorization if not authorized the penalty is 50.00% reduct

//Urgent care services
Benefit member service-category"**urgent care services**" rendered by specialty"**Member's PCP**" 100% of service cost co-pay $15.00
Benefit member service-category"**urgent care services**" rendered by specialty"**Medical specialist**" 100% of service cost co-pay $25.00

// All other covered charges 100%
for all other covered services:100.00 % of service cost

For Out Of Network Services

Benefits:

Exclusions

//Maintenance rehabilitation/services are not covered
Not Covered: member service-category"**Maintenance rehabilitation**"

//Infertility drugs are not covered
Not Covered: member service-category"**Infertility Drugs**"

//Prescription mail order not covered
Not Covered: member service-category"**Prescription Mail Order**"

//Infertility services not covered
Not Covered: member service-category"**Infertility services**"

//Family planning - Tubal ligations not covered
Not Covered: member service-category"**Family Planning-Tubal ligations**"service "58600", "58670"

//Family planning - Vasectomy not covered
Not Covered: member service-category"**Family Planning-Vasectomy**"service "55250", "52648", "52601", "52648", "55200", "55300", "55400"

Limits
//Maximum lifetime benefit $2 million overall
Limit member to: $2000000.00 reimbursement per lifetime

//Maximum lifetime benefit of 30 days for inpatient substance abuse
Limit member to: 30 day(s), in-patient service-category"**substance abuse**" rendered for (diagnosis"304.0", "304.1", "304.2", "304.3"

Limit member to: 30 day(s): in-patient service-category "substance abuse" rendered for (diagnosis "304.0", "304.1", "304.2", "304.3", "304.4", "304.5", "304.6", "304.7", "304.8", "304.9", "305.0", "305.1", "305.2", "305.3", "305.4", "305.5", "305.6", "305.7", "305.8", "305.9"

//Maximum lifetime benefit of 30 visits for outpatient substance abuse
Limit member to: 30 visit(s): out-patient service-category "substance abuse" rendered for (diagnosis "304.0", "304.1", "304.2", "304.3", "304.4", "304.5", "304.6", "304.7", "304.8", "304.9", "305.0", "305.1", "305.2", "305.3", "305.4", "305.5", "305.6", "305.7", "305.8", "305.9"

//*Outpatient prescription drugs (quantity limitations may apply), $50 stand-alone deductible per calendar year,
// then 75% coinsurance (up to a 31-day supply) per prescription or refill

//Enhanced chiropractic care provides $500 maximum benefit per calendar year
Limit member to: $500.00 reimbursement: service-category "chiropractic" per calendar-year

//Outpatient rehabilitative services, limited to short-term, maximum of 60 visits per calendar year
Limit member to: 60 visit(s): out-patient service-category "rehabilitative services" per calendar-year

//Mental health services: inpatient, maximum of 30 days per lifetime
// In & Out-of-Network are combined benefits
Limit member to: 30 day(s): in-patient service-category "mental health services" per lifetime

//Mental health services: outpatient, maximum of 20 visits per calendar year
// In & Out-of-Network are combined benefits
Limit member to: 20 visit(s): out-patient service-category "mental health services" per calendar-year

Maximum Expenditures

//Individual out-of-pocket maximum, includes deductible
member out of pocket max: $2000.00 includes deductible payment per calendar-year

//Family out-of-pocket maximum (includes deductible, but excludes copayment)
family out of pocket max: $6000.000 includes deductible payment per calendar-year//excludes co-pay

Deductibles

//$200 single/$600 family
member deductible is: $200.00 includes covered payment co-insurance payment per calendar-year
family deductible is: $600.00 includes covered payment co-insurance payment per calendar-year

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//Inpatient hospital services (including physician and facility charges) is 75% coinsurance, subject to deductible
Benefit member in-patient service-category"inpatient hosptital services" 75.00% of service cost

//Outpatient hospital services/Ambulatory surgical center services is 75% coinsurance, subject to deductible
Benefit member out-patient service-category"outpatient hospital services" 75% of service cost

//Physician services: office visits (including specialists and chiropractors) is 75% coinsurance, subject to deductible
Benefit member service-category"office visit" service "99201", "99202", "99203",
"99204", "99205", "99211", "99212", "99213", "99214", "99215" 75 of service cost

//Laboratory tests and X-rays (office visit copay may apply for services received in physicians office)
//      is 75%, subject to deductible
Benefit member service-category"laboratory tests and x-rays" 75% of service cost
//XXXXX

//Routine Physicals covers 75% coinsurance, deductible waived
Benefit member service-category"routine physicals " service "99201", "99202", "99203",
"99204", "99205", "99211", "99212", "99213", "99214", "99215" 75 of service cost

//Enhanced chiropractic care covers 75% coinsurance, subject to deductible
Benefit member service-category"chiropractic care" 75 % of service cost

//Emergency room services requires $50 copay (waived if admitted), 75% coinsurance, deductible waived
Benefit member service-category"emergency room services" 7% of service cost co-pay $50.00
Waive co-pay if admitted from emergency room

//Ambulance services is 100% of eligible medical expenses, subject to deductible
Benefit member service-category"ambulance" service "A0021", "A0030", "A0040", "A0050", "A0080", "A0090", "A0100", "A0110", "A0120" , "A0130",
"A0210", "A0225", "A0300", "A0302", "A0304", "A0306", "A0308", "A0310", "A0320", "A0322", "A0324", "A0326", "A0328", "A0330", "A0340", "A0342'
"A0366", "A0370", "A0380", "A0382", "A0384", "A0390", "A0392", "A0394", "A0396", "A0398", "A0420", "A0422", "A0424", "A0888", "A0999" 100f ser

//Urgent care services is 75% coinsurance, subject to deductible
Benefit member service-category"urgent care services" 75% of service cost

//Outpatient rehabilitative services, is 75% coinsurance, subject to deductible
Benefit member out-patient service-category"rehabilitative services" 75% of service cost

//Skilled nursing facility services, is 75% coinsurance, subject to deductible
```

Benefit member service-category"skilled nursing facility" 75% of service cost requires authorization, if not authorized, the penalty is 50.00 %

//Hospice care services is 75% coinsurance, subject to deductible
Benefit member service-category"hospice care" at POS "34" 75 % of service cost requires authorization, if not authorized, the penalty is 50.00 %

//Home health care services (part-time and intermittent), is 75% coinsurance, subject to deductible
Benefit member service"99315", "99316", "99321", "99322", "99323", "99331", "99332", "99333" 75 of service cost requires referral, if not authc

//Corrective appliances and durable medical equipment, is 75% coinsurance, subject to deductible
Benefit member service-category"Corrective Appliances DME" 75% of service cost

//Mental health services: inpatient (Limited to short-term evaluation or crisis intervention)
// is 75% coinsurance, subject to deductible
Benefit member in-patient service-category"mental health services" 75% of service cost

//Mental health services: outpatient (Limited to short-term evaluation or crisis intervention)
// is 75% coinsurance, subject to deductible
Benefit member out-patient service-category"mental health services" 75% of service cost

//Substance abuse services: inpatient is 75% coinsurance, subject to deductible
Benefit member in-patient service-category"substance abuse" rendered for (diagnosis"304.0", "304.1", "304.2", "304.3",
"304.4", "304.5", "304.6", "304.7", "304.8", "304.9", "305.0", "305.1", "305.2", "305.3", "305.4", "305.5", "305.6", "305.7", "305.8", "305.9"

//Substance abuse services- outpatient is 75% coinsurance, subject to deductible
Benefit member out-patient service-category"substance abuse" rendered for (diagnosis"304.0", "304.1", "304.2", "304.3",
"304.4", "304.5", "304.6", "304.7", "304.8", "304.9", "305.0", "305.1", "305.2", "305.3", "305.4", "305.5", "305.6", "305.7", "305.8", "305.9"

// All other covered charges 75%
for all other covered services:75.00 % of service cost

Appendix B

Start ::= HICLUnit

HICLUnit ::= CompanyPolicy
| SupplierContract
| PlanContract

CompanyPolicy ::= BaseInfo CalculationPolicy

CalculationPolicy ::= "Fee" "Calculation" "Policies" (CalculationMethodLocationS)?
(CalculateUandCPercentileS)? (RBRVSConversionFactorS)?

RBRVSConversionFactorS ::= "RBRVS" (ConversionFactorS)?

CalculateUandCPercentileS ::= "calculate" "u" "and" "c" "with" "the" PercentileS

SupplierContract ::= "Contract" BaseInfo (CalculationPolicy)? (FeePayment)?
(RosterPractitionerReferenceList)? (ServiceAuthorizationRequirementSchedule)?
FeeSchedule

ServiceAuthorizationRequirementSchedule ::= "Services" "Encounter" "Authorizations"
"Required" (PractitionerRenderingAutorization)+

PractitionerRenderingAutorization ::= (RenderingPractitionerRoster)? (DeliverToSubscriptionRelationshipCondition)?
(ServiceDeliveryRequiringAuthorization)+

DeliverToSubscriptionRelationshipCondition ::= "to" "deliver" "services" "to" (SubscriptionRelationshipCondition)?

ServiceDeliveryRequiringAuthorization ::= (ServiceReceived)? ServiceAuthorizationRequired

FeeSchedule ::= "Reimbursement" "Schedule" (PractitionerRosterFeeSchedule)*
(GeneralSimpleFeeSchedule)?

GeneralSimpleFeeSchedule ::= "General" SimpleFeeSchedule

RosterPractitionerReferenceList ::= "Roster" PractitionerReferenceList

PractitionerReferenceList ::= "practitioner" IdentifierList

PractitionerRosterFeeSchedule ::= "Rendering" RenderingPractitionerRoster SimpleFeeSchedule (UseGeneralFee)?

UseGeneralFee ::= "Otherwise" "use" "the" "general" "schedule"

RenderingPractitionerRoster ::= RenderingPractitionerRosterItem (SemiRenderingPractitionerRosterItem)*

```
SemiRenderingPractitionerRosterItem ::= ";" RenderingPractitionerRosterItem
RenderingPractitionerRosterItem ::= ( SpecialtyReferenceList | PractitionerReferenceList )
SpecialtyReferenceList ::= "specialty" IdentifierList
SimpleFeeSchedule ::= ( SimpleFeeChoice )+
SimpleFeeChoice ::= SimpleFee
                  | DefaultFee
SimpleFee ::= ( ServiceForpatientType )? FeeCalculationPayment
ServiceForpatientType ::= "For" "covered" "services" ( ServiceReceived )? ( PatientType )?
DefaultFee ::= "for" "all" "other" ":" FeeCalculationPayment
PatientType ::= "delivered" "to" ServiceRecipient ( ProductRenderedRoster )?
ServiceRecipient ::= ( ServiceGeneralRecipientS | SubscriptionRelationshipCondition )
ServiceGeneralRecipientS ::= "members"
ProductRenderedRoster ::= "of" ProductRenderedRosterItem ( SemiproductRenderedRosterItem )*
SemiproductRenderedRosterItem ::= ";" ProductRenderedRosterItem
ProductRenderedRosterItem ::= ( ProductReferenceList | PlanReferenceList )
ProductReferenceList ::= "product" IdentifierList
PlanReferenceList ::= "plan" IdentifierList
FeeCalculationPayment ::= "the" "allowed" "fee" "is" FeeCalculationPaymentType
                          ( ServiceAuthorizationRequired )?
FeeCalculationPaymentType ::= ( TieredFeeCalculationPayment | FeeCalculation )
TieredFeeCalculationPayment ::= "determined" "by" "the" "following" "tiers" ":" ( FeeCalculationPaymentTierItem )+
FeeCalculationPaymentTierItem ::= "tier" ( OptTierEscalatesS )? ":" FeeCalculationTier "the" "allowed" "fee" "is"
                                  FeeCalculation ( FeePayment )?
OptTierEscalatesS ::= "escalates"
FeeCalculationTier ::= SimpleFeeCalculationTier
SimpleFeeCalculationTier ::= TierExpression ( ServiceForpatientType )? ( ByrenderingPractitionerRoster )?
                             ( BenefitInterval )?
ByrenderingPractitionerRoster ::= "by" RenderingPractitionerRoster
TierExpression ::= OrTierValue
OrTierValue ::= AndTierValue ( "or" AndTierValue )*
```

```
AndTierValue ::= TierValueExp ( "and" TierValueExp )*
TierValueExp ::= ( TierValue | NotTierValue | "(" TierExpression ")" )
NotTierValue ::= "not" "(" TierExpression ")"
TierValue ::= ( HRelOp )? SimpleTierValue
SimpleTierValue ::= ( CompanyParticipationBenefitValueS | ConfinementDaysBenefitValueS |
                      VisitBenefitValueS | ConfinementNumberBenefitValueS |
                      ServiceUnitBenefitValueS )
PercentCalculationS ::= ( FloatNumber | Integer ) "%" "of"
FeeCalculation ::= ( SimpleFeeCalculation | FunctionFeeCalculation )
FunctionFeeCalculation ::= "the" Function "of" "the" "following" "options" ":" FeeCalculationList
SimpleFeeCalculation ::= ( PercentCalculationS )? CalculationMethod ( FeeMethodUnavailable )?
FeeMethodUnavailable ::= "," "if" "service" "calculation" "is" "undetermined" "then" FeeCalculation
Function ::= ( MaximumS | MinimumS | AverageS )
MaximumS ::= ( HigherS | HighestS )
MinimumS ::= ( LowerS | LowestS )
HigherS ::= "higher"
HighestS ::= "highest"
LowerS ::= "lower"
LowestS ::= "lowest"
AverageS ::= "average"
FeeCalculationList ::= OptionFeeCalculation ( SemiOptionFeeCalculation )*
SemiOptionFeeCalculation ::= ";" OptionFeeCalculation
OptionFeeCalculation ::= "option" ":" FeeCalculation
CalculationMethod ::= ( RBRVSCalculationMethod | UandCCalculationMethod |
                        PercentBilledCalculationMethodS | PerFeeUnitCalculationMethodS |
                        FlatFeeCalculationMethod | CapitationCalculationMethod )
CalculationMethodLocationS ::= "calculate" "with" "zip" "code" String
CapitationCalculationMethod ::= "capitated" "as" ( CapitationRate )*
CapitationRate ::= ( SubscriptionRelationshipCondition )? FloatNumber "per" "member" "per" "month"
FlatFeeCalculationMethod ::= "fee" Currency
PerFeeUnitCalculationMethodS ::= Currency BenefitInterval
```

```
PercentBilledCalculationMethodS ::= "the" "billed" "amount"
UandCCalculationMethod ::= "the" ( PercentileS )? "usual" "and" "customary"
                           "costs" ( StandardScheduleCalculation )? ( CalculationMethodLocationS )?
                           ( ConversionFactorS )?
PercentileS ::= ( FloatNumber | Integer ) "th" "percentile"
RBRVSCalculationMethod ::= "RBRVS" ( StandardScheduleCalculation )? ( CalculationMethodLocationS )?
                           ( ConversionFactorS )?
StandardScheduleCalculation ::= ( CurrentScheduleS | ScheduleS )
ConversionFactorS ::= "conversion" "factor" FloatNumber
CurrentScheduleS ::= "current" "schedule"
ScheduleS ::= "schedule" Identifier
FeePayment ::= "payment" "terms" ( FeePaymentTermItem )+
FeePaymentTermItem ::= ( FeePaymentWithhold | FeePaymentSupplierRisk )
FeePaymentWithhold ::= "Withhold" ( FloatNumber | Integer ) "%"
FeePaymentSupplierRisk ::= "Supplier" "risk" ( FloatNumber | Integer ) "%"
PlanContract ::= "Plan" BaseInfo BenefitSchedule
BaseInfo ::= IdentifierS ( EffectiveDateS )? ( ExpirationDateS )?
IdentifierS ::= "identifier" IdString
IdString ::= String
EffectiveDateS ::= "effective-date" String
ExpirationDateS ::= "expiration-date" String
BenefitSchedule ::= ( ExclusionSchedule )? ( LimitSchedule )? ( MaximumsSchedule )?
                    ( DeductibleSchedule )? ( BenefitAuthorizationRequirementSchedule )?
                    ServiceSupplierSchedule
ExclusionSchedule ::= "Exclusions" ( SubscriptionRelationshipExclusion )+
SubscriptionRelationshipExclusion ::= "Not" "Covered" ":" SubscriptionRelationshipCondition ( ServiceReceived )+
LimitSchedule ::= "Limits" ( NetworkTierReciprocal )* ( SubscriptionRelationshipLimit )+
NetworkTierReciprocal ::= "Apply" PercentCalculationS NetworkTierType "to" "this"
                          "category" ( CurrencyCap )?
NetworkTierType ::= ( NetworkS | NotNetworkS | NonNetworkS | NotLocationS )
NetworkS ::= "network"
```

NotNetworkS ::= "not-network"
NonNetworkS ::= "non-network"
NotLocationS ::= "not-location"
CurrencyCap ::= "up" "to" Currency
SubscriptionRelationshipLimit ::= "Limit" SubscriptionRelationshipCondition "to" ":" (BenefitReceived)+
MaximumsSchedule ::= "Maximum" "Expenditures" (NetworkTierReciprocal)*
(MaximumAffectsCoPayment)? (SubscriptionRelationshipMaximum)+
MaximumAffectsCoPayment ::= "Once" "the" "max" "is" "reached" "," "co-pays" "are" "waived"
SubscriptionRelationshipMaximum ::= SubscriptionRelationshipCondition "out" "of" "pocket" "max" ":" (PaidAmount)+
DeductibleSchedule ::= "Deductibles" (NetworkTierReciprocal)* (DeductibleCarryOver)?
(SubscriptionRelationshipDeductible)+
DeductibleCarryOver ::= "Any" "deductible" "amount" "incurred" "during" "the" "last" Integer "months" "of"
"the" "year" "will" "be" "applied" "to" "the" "following" "year"
SubscriptionRelationshipDeductible ::= SubscriptionRelationshipCondition "deductible" "is" ":" (PaidAmount)+
BenefitAuthorizationRequirementSchedule ::= "Services" "Requiring" "Authorizations" (SubscriptionRelationshipAuthorization)+
SubscriptionRelationshipAuthorization ::= SubscriptionRelationshipCondition "to" "receive" "services"
"for" (ServiceRequiringAuthorization)+
ServiceRequiringAuthorization ::= ServiceReceived BenefitAuthorizationRequired
ServiceSupplierSchedule ::= "Benefit" "Schedule" (EmergencyRoomAdmitCoInsuranceWaiver)?
(NetworkBenefit)* (NonNetworkBenefit)? (NotNetworkBenefit)?
(NotLocationBenefit)?
EmergencyRoomAdmitCoInsuranceWaiver ::= "Waive" "co-pay" "if" "admitted" "from" "emergency" "room"
NetworkBenefit ::= "For" "In-Network" "Services" "Rendered" "By" NetworkSupplier BenefitProvision
BenefitProvision ::= "Benefits" ":" (EmergencyRoomAdmitCoInsuranceWaiver)? (ExclusionSchedule)?
(LimitSchedule)? (MaximumsSchedule)? (DeductibleSchedule)?
(BenefitAuthorizationRequirementSchedule)? Benefit
NetworkSupplier ::= (SupplierContractReference | SupplierNetworkReference)
SupplierContractReference ::= "supplier-contract" IdentifierList
SupplierNetworkReference ::= "supplier-network" String
Benefit ::= (Benefits)+
Benefits ::= SimpleBenefit

```
                          | DefaultBenefit
            SimpleBenefit ::= "Benefit" ( SubscriptionRelationshipCondition )? ServiceReceived Indemnification
                              ( BenefitAuthorizationRequired )? ( MaximumAffectsCoPayment )?
                              ( EmergencyRoomAdmitCoInsuranceWaiver )?
           DefaultBenefit ::= "for" "all" "other" "covered" "services" ":" Indemnification
        NonNetworkBenefit ::= "For" "Out" "Of" "Network" "Services" BenefitProvision
        NotNetworkBenefit ::= "For" "Services" "Unavailable" "in" "Network" BenefitProvision
       NotLocationBenefit ::= "For" "Services" "Out" "Of" "Service" "Location" BenefitProvision
          ServiceReceived ::= ( ServiceChoice )+
            ServiceChoice ::= AdmittingStatus
                          | ServiceUrgency
                          | ReceivedService
                          | RenderingProvider
          AdmittingStatus ::= SimpleAdmittingStatus
    SimpleAdmittingStatus ::= ( InPatientS | OutPatientS )
               InPatientS ::= "in-patient"
              OutPatientS ::= "out-patient"
           ServiceUrgency ::= ( NotS )? SimpleTreatmentUrgency
   SimpleTreatmentUrgency ::= ( MedicalEmergencyS | MedicalUrgentCareS | MedicalNonEmergencyS )
       MedicalEmergencyS ::= "emergency-care"
      MedicalUrgentCareS ::= "urgent-care"
    MedicalNonEmergencyS ::= "normal-care"
          ReceivedService ::= ( NotS )? SimpleReceivedService
                     NotS ::= "other" "than"
    SimpleReceivedService ::= SimpleReceivedServiceItem ( SemiSimpleReceivedServiceItem )*
SimpleReceivedServiceItem ::= ( TreatmentServiceForProblem | TreatmentServiceGroupForProblem |
                              TreatmentAppropriateForProblem )
TreatmentServiceForProblem ::= ServiceReferenceList ( RenderedForProblem )?
     ServiceReferenceList ::= "service" IdentifierList
       RenderedForProblem ::= "rendered" "for" "(" TreatmentProblemList ")"
```

TreatmentProblemList ::= TreatmentProblemItem (CommaTreatmentProblemItem)*
TreatmentProblemItem ::= (DiagnosisReferenceList | MDCReferenceList | DRGReferenceList)
DiagnosisReferenceList ::= "diagnosis" IdentifierList
MDCReferenceList ::= "MDC" IdentifierList
DRGReferenceList ::= "DRG" IdentifierList
CommaTreatmentProblemItem ::= "," TreatmentProblemItem
TreatmentServiceGroupForProblem ::= TreatmentServiceGroupType (ExcludedTreatmentService)?
(RenderedForProblem)?
TreatmentServiceGroupType ::= (ServiceCategoryReferenceList | TypeOfServiceReferenceList)
ServiceCategoryReferenceList ::= "service-category" IdentifierList
TypeOfServiceReferenceList ::= "TOS" IdentifierList
ExcludedTreatmentService ::= "excluding" "(" TreatmentService ")"
TreatmentService ::= TreatmentServiceItem (CommaTreatmentServiceItem)*
TreatmentServiceItem ::= (TreatmentServiceGroupType | ServiceReferenceList)
CommaTreatmentServiceItem ::= "," TreatmentServiceItem
TreatmentAppropriateForProblem ::= "appropriate" "services" "for" ":" TreatmentProblemItem
(ExcludedTreatmentService)?
SemiSimpleReceivedServiceItem ::= ";" SimpleReceivedServiceItem
RenderingProvider ::= (NotS)? ServiceProvider
ServiceProvider ::= (ServiceProviderSite | RenderedByPractitioner | RenderedBySupplier)
ServiceProviderSite ::= (RenderingFacilityOfService | RenderingPlaceOfService)
RenderingFacilityOfService ::= "in" "a" FacilityOfService "site"
FacilityOfService ::= (FacilityS | NonFacilityS)
FacilityS ::= "facility"
NonFacilityS ::= "non-facility"
RenderingPlaceOfService ::= "at" "POS" IdentifierList
RenderedByPractitioner ::= "rendered" "by" SpecialtyReferenceList (OptNotServiceProviderSite)?
OptNotServiceProviderSite ::= (NotS)? ServiceProviderSite
RenderedBySupplier ::= "delivered" "by" ClassificationReferenceList
ClassificationReferenceList ::= "classification" IdentifierList

```
BenefitAuthorizationRequired ::= "requires" ServiceAuthorizationType NonAuthorizationPenalty
ServiceAuthorizationType ::= ( ServicePreCertificationS | ServiceReferralS | ServiceAuthorizationS )
ServicePreCertificationS ::= "pre-certification"
ServiceReferralS ::= "referral"
ServiceAuthorizationS ::= "authorization"
NonAuthorizationPenalty ::= "," "if" "not" "authorized" "," "the" "penalty" "is"
    ServiceNonAuthorizationPenaltyType
    ( NonAuthorizationDeductibleLossPenaltyType )?
    ( NonAuthorizationMaximumLossPenaltyType )?
ServiceNonAuthorizationPenaltyType ::= ( NonAuthorizationNoReimbursementPenalty |
    NonAuthorizationReductionBenefitPenalty )
NonAuthorizationNoReimbursementPenalty ::= "no" "reimbursement"
NonAuthorizationReductionBenefitPenalty ::= NonAuthorizationReductionBenefitPenaltyType "reduction" "in" "benefit"
NonAuthorizationReductionBenefitPenaltyType ::= ( NonAuthorizationPercentageBenefitPenalty | NonAuthorizationValueLossPenalty )
NonAuthorizationPercentageBenefitPenalty ::= FloatNumber "%"
NonAuthorizationValueLossPenalty ::= Currency
NonAuthorizationDeductibleLossPenaltyType ::= "non-application" "of" "deductible" "credit"
NonAuthorizationMaximumLossPenaltyType ::= "non-application" "of" "out" "of" "pocket" "maximum" "credit"
ServiceAuthorizationRequired ::= ServiceAuthorizationType "required"
SubscriptionRelationshipCondition ::= SubscriptionRelationshipConditionItem
    ( CommaSubscriptionRelationshipConditionItem )*
CommaSubscriptionRelationshipConditionItem ::= "," SubscriptionRelationshipConditionItem
SubscriptionRelationshipConditionItem ::= SubscriptionRelationshipS ( SubscriptionRelationshipWithCondition )?
SubscriptionRelationshipS ::= ( SubscriberS | FamilyS | MemberS | SpouseS | DependantS | ChildS | AdoptedChildS
    | ChildOfDependantS | SpouseOfDependantS )
SubscriberS ::= "subscriber"
FamilyS ::= "family"
MemberS ::= "member"
SpouseS ::= "spouse"
DependantS ::= "dependant"
ChildS ::= "child"
```

AdoptedChildS ::= "adopted-child"
ChildOfDependantS ::= "child-of-dependant"
SpouseOfDependantS ::= "spouse-of-dependant"
SubscriptionRelationshipWithCondition ::= "with" SimpleAttributeExpression
SimpleAttributeExpression ::= OrAttributeExpression
OrAttributeExpression ::= AndAttributeExpression ("or" AndAttributeExpression)*
AndAttributeExpression ::= AttributeExpression ("and" AttributeExpression)*
AttributeExpression ::= (SimpleAttribute | NotAttributeExpression | "(" SimpleAttributeExpression ")")
NotAttributeExpression ::= "not" "(" SimpleAttributeExpression ")"
SimpleAttribute ::= RelationshipAttributeS RelationshipAttributeCondition
RelationshipAttributeS ::= (GenderAttributeS | AgeAttributeS)
GenderAttributeS ::= "gender"
AgeAttributeS ::= "age"
RelationshipAttributeCondition ::= HRelOp ValueList
HRelOp ::= (EQ | NEQ | GT | LT | GTE | LTE | RIn | InBetween)
EQ ::= ("equalTo" | "=")
NEQ ::= ("notequalTo" | "!=")
GT ::= ("greaterThan" | ">")
LT ::= ("lessThan" | "<")
GTE ::= ("greaterThanOrEqualTo" | ">=")
LTE ::= ("lessThanOrEqualTo" | "<=")
RIn ::= "in"
InBetween ::= "between"
ValueList ::= Value (CommaValue)*
CommaValue ::= "," Value
Value ::= String
BenefitReceived ::= BenefitValue (ColonServiceReceived)? BenefitInterval
BenefitValue ::= (CompanyParticipationBenefitValueS | ConfinementDaysBenefitValueS | VisitBenefitValueS | ConfinementNumberBenefitValueS | ServiceUnitBenefitValueS)

CompanyParticipationBenefitValueS ::= Currency "reimbursement"
ConfinementDaysBenefitValueS ::= (Integer | FloatNumber) "day(s)"
VisitBenefitValueS ::= Integer "visit(s)"
ConfinementNumberBenefitValueS ::= Integer "confinement(s)"
ServiceUnitBenefitValueS ::= Integer "unit(s)"
ColonServiceReceived ::= ":" ServiceReceived
BenefitInterval ::= "per" BenefitIntervalType
BenefitIntervalType ::= (SimpleValueUnitInterval | ServiceEncounterAdmitType | GeneralCaseS | GeneralUnitS | GeneralDiem | SimpleTreatmentUrgency | ServiceReceived)
GeneralCaseS ::= "case"
GeneralUnitS ::= "unit"
GeneralDiem ::= "diem"
SimpleValueUnitInterval ::= ValueMeasurement (ToValueMeasurement)?
ToValueMeasurement ::= "to" ValueMeasurement
ValueMeasurement ::= (OptDecimalStatement)? MeasurementType
OptDecimalStatement ::= (FloatNumber | Integer)
MeasurementType ::= (TimeUnit | VolumeUnit | WeightUnit | DistanceUnit CurrencyUnit)
TimeUnit ::= (Sec | Min | Hour | Day | Week | Month | Year | Century | Lifetime | Forever | Beginning | End | CalendarYear | PlanYear)
VolumeUnit ::= (CC | ML | Litre | Pint | Quart | Gallon)
WeightUnit ::= (Ounce | Lbs | Gram | KiloGram)
DistanceUnit ::= (MM | CM | Meter | KM | INCH | FEET | YARD | MILE)
CurrencyUnit ::= Dollar
Dollar ::= "$"
Sec ::= "sec"
Min ::= "min"
Hour ::= "hour"
Day ::= "day"
Week ::= "week"
Month ::= "month"

Year ::= "year"
Century ::= "century"
Lifetime ::= "lifetime"
Forever ::= "forever"
Beginning ::= "beginning"
End ::= "end"
CalendarYear ::= "calendar-year"
PlanYear ::= "plan-year"
CC ::= "cc"
ML ::= "ml"
Litre ::= "L"
Pint ::= "pint"
Quart ::= "quart"
Gallon ::= "gallon"
Ounce ::= "ounce"
Lbs ::= "lbs"
Gram ::= "gram"
KiloGram ::= "kilogram"
MM ::= "mm"
CM ::= "cm"
Meter ::= "m"
KM ::= "km"
INCH ::= "inch"
FEET ::= "feet"
YARD ::= "yard"
MILE ::= "mile"
ServiceEncounterAdmitType ::= (InpatientEncounterS | OutpatientEncounterS | GeneralEncounterS)
InpatientEncounterS ::= "confinement"
OutpatientEncounterS ::= "visit"
GeneralEncounterS ::= "encounter"

```
PaidAmount ::= CurrencyAmountS ( IncludedPaymentCategory )? ( ServiceReceived )?
               BenefitInterval
CurrencyAmountS ::= Currency
IncludedPaymentCategory ::= "includes" ( SubscriptionPaymentCategory )+
SubscriptionPaymentCategory ::= PaymentCategory "payment"
PaymentCategory ::= ( CopayS | CoinsuranceS | DeductibleS | NonCoveredS | CoveredS | PremiumS |
                    TotalS )
CopayS ::= "co-pay"
CoinsuranceS ::= "co-insurance"
DeductibleS ::= "deductible"
NonCoveredS ::= "non-covered"
CoveredS ::= "covered"
PremiumS ::= "premium"
TotalS ::= "total"
Indemnification ::= ( BenefitCalculationTier )+
BenefitCalculationTier ::= IndemnityCalculation ( BenefitTierTermination )?
IndemnityCalculation ::= CompanyParticipation ( CopayAmount )? ( DeductibleWaiver )?
CompanyParticipation ::= ( FloatNumber | Integer ) "%" "of" "service" "cost"
CopayAmount ::= "co-pay" CurrencyAmountS
DeductibleWaiver ::= "no" "deductible"
BenefitTierTermination ::= "until" BenefitInteraction
BenefitInteraction ::= SubscriptionRelationshipCondition BeneficiaryInteraction
BeneficiaryInteraction ::= ( BenefitReceiptInteraction | MemberPaymentInteraction )
BenefitReceiptInteraction ::= "receives" BenefitValue "in" "benefits" ( ServiceBenefitInterval )?
ServiceBenefitInterval ::= ( ForServiceReceived )? BenefitInterval
ForServiceReceived ::= "for" ( ServiceReceived )?
MemberPaymentInteraction ::= "pays" CurrencyAmountS "in" SubscriptionPaymentCategory
                             ( ServiceBenefitInterval )?
IdentifierList ::= Id ( CommaIdentifier )*
CommaIdentifier ::= "," Id
```

Id ::= (Identifier | String)

String ::= <STRING_LITERAL>

Identifier ::= <IDENTIFIER>

Integer ::= <INTEGER_LITERAL>

Currency ::= "$" FloatNumber

FloatNumber ::= <FLOATING_POINT_LITERAL>

Appendix C

```
// XYZ Health Systems Facility Contract for HCC-7
// Revised 3/1/01 6:15pm

Contract

//BaseInfo
identifier "XYZ Health Systems"
effective-date "08-01-2001 12:00am"
expiration-date "12-31-2003 12:00am" // Note there is an overlap with an old contract going back to 1997

// Facility-Supplier list Note: this will be included in next version
// List of all facilities coverd by this contract/
// Roster supplier Name "XYZ Roster"
//                      "86-0957500",   // Hospital1
//                      "020149",       // Hospital2
//                      "86-0394149",   // Hospital3
//                      "86-0976257",   // Hospital4
//                      "021379",       // Hospital5
//                      "36 3386394",   // Hospital6


// This Roster is specifically for the facilities subject to Zone pricing
// Roster supplier Name "Zone Roster"
//                      "86-0957500",   // Hospital1
//                      "020149",       // Hospital2

// MEDICARE+CHOICE Roster/
// Roster supplier Name "MEDICARE+CHOICE Roster"
//                      "86-0394149",   // Hospital3
//                      "86-0976257",   // Hospital4
//                      "021379",       // Hospital5
//                      "36-3386394",   // Hospital6
//ServiceAuthorizationRequirementSchedule
// Note: in future release we will be able to specifiy that Auths are needed for all "elective services" based on UB92 admit code
//Services Encounter Authorizations Required to deliver service service-category "elective service"  to member authorization required

//////////////
//FeeSchedules
''''''''''''''
```

```
//////////////

//////////////////////
// Roster Fee Schedules
//////////////////////

Reimbursement Schedule

//*************************
//* HMO-ZONE FEE SCHEDULE *
//*************************

Rendering practitioner "Zone Roster"    // Note: in next version keyword "practitioner"  will be expanded to specify "supplier"

// Note: we will need to do additional analysis with Healthnet to fully specify the conditions for meeting "zone" criteria
// Note2: This schedule requires further analysis and consultation with Healthnet

// Routine Med/Surg
For covered services inpatient service
                "110", "112", "113", "117",                    // Note: Rev Codes
                "119", "120", "121", "122", "123", "127",
                "129", "130", "131", "132", "133", "137",
                "139", "140", "141", "142", "143", "147", "149"
                other than appropriate services for: DRG "370", "371", "372", "373", "374", "375"
        delivered to members of product "HMO"
        the allowed fee is determined by the following tiers
                tier : lessThan 3000 day(s) the allowed fee is $ 2695.00 per diem
                tier : greaterThanOrEqualTo 3000 day(s) and lessThan 4000 day(s) the allowed fee is $ 2329.00 per diem
                tier : greaterThanOrEqualTo 4000 day(s) and lessThan 6000 day(s) the allowed fee is $ 1990.00 per diem

// Intermediate/DOU
For covered services inpatient service
                "160", "206", "214"                    // Note: Rev Codes
        delivered to members of product "HMO"
        the allowed fee is determined by the following tiers
                tier : lessThan 3000 day(s) the allowed fee is $ 4100.00 per diem
                tier : greaterThanOrEqualTo 3000 day(s) and lessThan 4000 day(s) the allowed fee is $ 3550.00 per diem
                tier : greaterThanOrEqualTo 4000 day(s) and lessThan 6000 day(s) the allowed fee is $ 2988.00 per diem
```

```
// Special Care (PICU/ICU/CCU/NICU)
For covered services inpatient service
                "174", "175", "200", "201", "202", "203",                    // Note: Rev Codes
                "208", "209", "210", "211", "212", "213", "219"
        delivered to members of product "HMO"
        the allowed fee is determined by the following tiers
                tier : lessThan 3000 day(s) the allowed fee is $ 4100.00 per diem
                tier : greaterThanOrEqualTo 3000 day(s) and lessThan 4000 day(s) the allowed fee is $ 3550.00 per diem
                tier : greaterThanOrEqualTo 4000 day(s) and lessThan 6000 day(s) the allowed fee is $ 2988.00 per diem

// OB Vaginal Delivery
For covered services inpatient service
                "110", "111", "112", "113", "117",                   // Note: Rev Codes
                "119", "120", "121", "122", "123", "127",
                "129", "130", "131", "132", "133", "137",
                "139", "140", "141", "142", "143", "147", "149"
                ; appropriate services for: DRG "372", "373", "374", "375"
        delivered to members of product "HMO"
        the allowed fee is determined by the following tiers
                tier : lessThan 3000 day(s) the allowed fee is $ 1587.00 per diem
                tier : greaterThanOrEqualTo 3000 day(s) and lessThan 4000 day(s) the allowed fee is $ 1367.00 per diem
                tier : greaterThanOrEqualTo 4000 day(s) and lessThan 6000 day(s) the allowed fee is $ 1206.00 per diem

// OB C-Section Delivery
For covered services inpatient service
                "110", "111", "112", "113", "117",                   // Note: Rev Codes
                "119", "120", "121", "122", "123", "127",
                "129", "130", "131", "132", "133", "137",
                "139", "140", "141", "142", "143", "147", "149"
                ; appropriate services for: DRG "370", "371"
        delivered to members of product "HMO"
        the allowed fee is determined by the following tiers
                tier : lessThan 3000 day(s) the allowed fee is $ 1587.00 per diem
                tier : greaterThanOrEqualTo 3000 day(s) and lessThan 4000 day(s) the allowed fee is $ 1367.00 per diem
                tier : greaterThanOrEqualTo 4000 day(s) and lessThan 6000 day(s) the allowed fee is $ 1206.00 per diem

// Newborn Nursery
For covered services inpatient service
                "170", "171", "172", "173"                   // Note: Rev Codes
```

```
            ; appropriate services for: DRG "385", "386", "387", "388", "389", "390", "391"
        delivered to members of product "HMO"
        the allowed fee is determined by the following tiers
                tier : lessThan 3000 day(s) the allowed fee is $ 300.00 per diem
                tier : greaterThanOrEqualTo 3000 day(s) and lessThan 4000 day(s) the allowed fee is $ 278.00 per diem
                tier : greaterThanOrEqualTo 4000 day(s) and lessThan 6000 day(s) the allowed fee is $ 235.00 per diem

// Rehabilitation
For covered services inpatient service
                "118", "128", "138", "148"                      // Note: Rev Codes
        delivered to members of product "HMO"
        the allowed fee is determined by the following tiers
                tier : lessThan 3000 day(s) the allowed fee is $ 845.00 per diem
                tier : greaterThanOrEqualTo 3000 day(s) and lessThan 4000 day(s) the allowed fee is $ 780.00 per diem
                tier : greaterThanOrEqualTo 4000 day(s) and lessThan 6000 day(s) the allowed fee is $ 660.00 per diem

// Pet codes
// SNF
// SNF w/ Vent
// Outpatient

//*********************************
//* MEDICARE+CHOICE FEE SCHEDULE *
//*********************************

Rendering practitioner "MEDICARE+CHOICE Roster"

// Standard Inpatient/Medical/Surgical/Pediatric
For covered services inpatient service "111", "113", "120", "121", "123"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is the lowerof the following options:
                option : $ 970.00 per diem ;
                option : 100 % of the billed amount

// ICU/CCU/Post ICU/Post CCU
For covered services inpatient service "200", "201", "206", "210", "214", "219"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is the lowerof the following options:
                option : $ 1642.00 per diem ;
```

option : 100 % of the billed amount

// OB - Vaginal
For covered services inpatient appropriate services for: DRG "372", "373", "374", "375"
delivered to members of product "MEDICARE+CHOICE"
the allowed fee is $ 960.00 per diem

// OB - C-Section
For covered services inpatient appropriate services for: DRG "370", "371"
delivered to members of product "MEDICARE+CHOICE"
the allowed fee is $ 960.00 per diem

// Newborn NeoNatal ICU
For covered services inpatient service "174", "175"
delivered to members of product "MEDICARE+CHOICE"
the allowed fee is $ 1397.00 per diem

// Newborn Boarder or Regular Nursery
For covered services inpatient service "171", "172", "173"
delivered to members of product "MEDICARE+CHOICE"
the allowed fee is $ 294.00 per diem

// Medical Rahabilitation
For covered services inpatient service "128"
delivered to members of product "MEDICARE+CHOICE"
the allowed fee is $ 622.00 per diem

// Outpatient Services - Default Fee schdule
For covered services outpatient other than service
// Ambluatory Surgery sepecifcally excluded -> covered by contract with Samaritan SurgiCenters of AZ
"10000", "10001", "10002", "10003", "10004", "10005", "10006", "10007", "10008", "10009",
"10010", "10011", "10012", "10013", "10014", "10015", "10016", "10017", "10018", "10019",
"10020", "10021", "10022", "10023", "10024", "10025", "10026", "10027", "10028", "10029",
"10030", "10031", "10032", "10033", "10034", "10035", "10036", "10037", "10038", "10039",
"10040", "10041", "10042", "10043", "10044", "10045", "10046", "10047", "10048", "10049",
"10050", "10051", "10052", "10053", "10054", "10055", "10056", "10057", "10058", "10059",
"10060", "10061", "10062", "10063", "10064", "10065", "10066", "10067", "10068", "10069",
"10979",

```
// These codes covered in case rates below
        "610", "611", "612", "619",
        "350", "351", "352", "359",
        "480",
        "790"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is 40 % of the billed amount

// Outpatient Services MRI
For covered services outpatient service "610", "611", "612", "619"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is $ 650.00 per case

// Outpatient Services CTs
For covered services outpatient service "350", "351", "352", "359"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is $ 650.00 per case

// Outpatient Services Heart Catherterization
For covered services outpatient service "480"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is $ 2651.00 per case

// Outpatient Services Lithotripsy
For covered services outpatient service "790"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is $ 3520.00 per case

// Emergency Room Services - Urgent Care
For covered services urgentcare service
        "99201", "99202", "99203", "99204", "99205",
        "99211", "99212", "99213", "99214", "99215",
        "99025", "99058"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is $ 75.00 per case

// Emergency Room Services - Emergency Room
For covered services service"450"
        delivered to members of product "MEDICARE+CHOICE"
```

```
        the allowed fee is $ 295.00 per case


// Observation
For covered services service"760", "762", "769"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is 25 % of the billed amount

// Professioanl Fees - default
For covered services servicecategory "Professional Services" //Note: use of service category in next release
        other than service "981" // covered below
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is 100% of RBRVS schedule PHRVS

// Professioanl Fees - 981
For covered services service"981"
        delivered to members of product "MEDICARE+CHOICE"
        the allowed fee is 40 % of the billed amount

General

//********************
//* HMO FEE SCHEDULE *
//********************

// Standard Inpatient/Medical/Surgical/Pediatric
For covered services inpatient service "111", "113", "120", "121", "123"
        delivered to members of product "HMO"
        the allowed fee is the lowerof the following options:
                option : $ 990.00 per diem ;
                option : 100 % of the billed amount

// ICU/CCU/Post ICU/Post CCU
For covered services inpatient service "200", "201", "206", "210", "214", "219"
        delivered to members of product "HMO"
        the allowed fee is the lowerof the following options:
                option : $ 1691.00 per diem ;
                option : 100 % of the billed amount
```

```
// OB - Vaginal
For covered services inpatient appropriate services for: DRG "372", "373", "374", "375"
        delivered to members of product "HMO"
        the allowed fee is $ 965.00 per diem

// OB - C-Section
For covered services inpatient appropriate services for: DRG "370", "371"
        delivered to members of product "HMO"
        the allowed fee is $ 965.00 per diem

// Newborn NeoNatal ICU
For covered services inpatient service "174", "175"
        delivered to members of product "HMO"
        the allowed fee is $ 1397.00 per diem

// Newborn Boarder or Regular Nursery
For covered services inpatient service "171", "172", "173"
        delivered to members of product "HMO"
        the allowed fee is $ 294.00 per diem

// Medical Rahabilitation
For covered services inpatient service "128"
        delivered to members of product "HMO"
        the allowed fee is $ 622.00 per diem

// Outpatient Services - Default Fee schdule
For covered services outpatient other than service
        // Ambluatory Surgery sepecifcally excluded -> covered by contract with Samaritan SurgiCenters of AZ
        "10000", "10001",  "10002", "10003", "10004", "10005", "10006", "10007", "10008", "10009",
        "10010", "10011",  "10012", "10013", "10014", "10015", "10016", "10017", "10018", "10019",
        "10020", "10021",  "10022", "10023", "10024", "10025", "10026", "10027", "10028", "10029",
        "10030", "10031",  "10032", "10033", "10034", "10035", "10036", "10037", "10038", "10039",
        "10040", "10041",  "10042", "10043", "10044", "10045", "10046", "10047", "10048", "10049",
        "10050", "10051",  "10052", "10053", "10054", "10055", "10056", "10057", "10058", "10059",
        "10060", "10061",  "10062", "10063", "10064", "10065", "10066", "10067", "10068", "10069",
        "10979",
        // These codes covered in case rates below
        "610", "611", "612", "619",
        "350", "351", "352", "359"
```

```
        "480",
        "790"
        delivered to members of product "HMO"
        the allowed fee is 63 % of the billed amount

// Outpatient Services MRI
For covered services outpatient service "610", "611", "612", "619"
        delivered to members of product "HMO"
        the allowed fee is $ 650.00 per case

// Outpatient Services CTs
For covered services outpatient service "350", "351", "352", "359"
        delivered to members of product "HMO"
        the allowed fee is $ 650.00 per case

// Outpatient Services Heart Catherterization
For covered services outpatient service "480"
        delivered to members of product "HMO"
        the allowed fee is $ 2651.00 per case

// Outpatient Services Lithotripsy
For covered services outpatient service "790"
        delivered to members of product "HMO"
        the allowed fee is $ 3520.00 per case

// Emergency Room Services - Urgent Care
For covered services urgentcare service
        "99201", "99202", "99203", "99204", "99205",
        "99211", "99212", "99213", "99214", "99215",
        "99025", "99058"
        delivered to members of product "HMO"
        the allowed fee is $ 75.00 per case

// Emergency Room Services - Emergency Room
For covered services service"450"
        delivered to members of product "HMO"
        the allowed fee is $ 295.00 per case
```

```
// Observation
For covered services service"760", "762", "769"
        delivered to members of product "HMO"
        the allowed fee is 25 % of the billed amount

// Professioanl Fees - default
For covered services servicecategory "Professional Services" //Note: use of service category in next release
        other than service "981" // covered below
        delivered to members of product "HMO"
        the allowed fee is 100% of RBRVS schedule FHRVS

// Professioanl Fees - 981
For covered services service"981"
        delivered to members of product "HMO"
        the allowed fee is 63 % of the billed amount



//********************
//* PPO FEE SCHEDULE *
//********************

// Standard Inpatient/Medical/Surgical/Pediatric
For covered services inpatient service "111", "113", "120", "121", "123"
        delivered to members of product "PPO"
        the allowed fee is the lowerof the following options:
                option : $ 1088.00 per diem ;
                option : 100 % of the billed amount

// ICU/CCU/Post ICU/Post CCU
For covered services inpatient service "200", "201", "206", "210", "214", "219"
        delivered to members of product 'PPO"
        the allowed fee is the lowerof the following options:
                option : $ 1960.00 per diem ;
                option : 100 % of the billed amount

// OB - Vaginal
For covered services inpatient appropriate services for: DRG "372", "373", "374", "375"
```

delivered to members of product "PPO"
the allowed fee is $ 1078.00 per diem

// OB - C-Section
For covered services inpatient appropriate services for: DRG "370", "371"
delivered to members of product "PPO"
the allowed fee is $ 1078.00 per diem

// Newborn NeoNatal ICU
For covered services inpatient service "174", "175"
delivered to members of product "PPO"
the allowed fee is $ 1666.00 per diem

// Newborn Boarder or Regular Nursery
For covered services inpatient service "171", "172", "173"
delivered to members of product "PPO"
the allowed fee is $ 323.00 per diem

// Medical Rahabilitation
For covered services inpatient service "128"
delivered to members of product "PPO"
the allowed fee is $ 686.00 per diem

// Outpatient Services - Default Fee schdule
//
For covered services outpatient other than service
// Ambluatory Surgery sepecifcally excluded
"10000", "10001", "10002", "10003", "10004", "10005", "10006", "10007", "10008", "10009",
"10010", "10011", "10012", "10013", "10014", "10015", "10016", "10017", "10018", "10019",
"10020", "10021", "10022", "10023", "10024", "10025", "10026", "10027", "10028", "10029",
"10030", "10031", "10032", "10033", "10034", "10035", "10036", "10037", "10038", "10039",
"10040", "10041", "10042", "10043", "10044", "10045", "10046", "10047", "10048", "10049",
"10050", "10051", "10052", "10053", "10054", "10055", "10056", "10057", "10058", "10059",
"10060", "10061", "10062", "10063", "10064", "10065", "10066", "10067", "10068", "10069",
"10979",
// These codes covered in case rates below
"610", "611", "612", "619",
"350", "351", "352", "359",
"480",

"790"
delivered to members of product "PPO"
the allowed fee is 70 % of the billed amount

// Outpatient Services MRI
For covered services outpatient service "610", "611", "612", "619"
delivered to members of product "PPO"
the allowed fee is $ 715.00 per case

// Outpatient Services CTs
For covered services outpatient service "350", "351", "352", "359"
delivered to members of product "PPO"
the allowed fee is $ 715.00 per case

// Outpatient Services Heart Catherterization
For covered services outpatient service "480"
delivered to members of product "PPO"
the allowed fee is $ 2916.00 per case

// Outpatient Services Lithotripsy
For covered services outpatient service "790"
delivered to members of product "PPO"
the allowed fee is $ 3872.00 per case

// Emergency Room Services Urgent Care
For covered services urgentcare service
"99201", "99202", "99203", "99204", "99205",
"99211", "99212", "99213", "99214", "99215",
"99025", "99058"
delivered to members of product "HMO"
the allowed fee is $ 83.00 per case

// Emergency Room Services - Emergency Room
For covered services service"450"
delivered to members of product "PPO"
the allowed fee is $ 325.00 per case

// Observation
For covered services service"760", "762", "769"

delivered to members of product "PPO"
the allowed fee is 28 % of the billed amount

// Professioanl Fees - default
For covered services servicecategory "Professional Services" //Note: use of service category in next release
other than service "981" // Covered below
delivered to members of product "PPO"
the allowed fee is 120% of RBRVS schedule FHRVS

// Professioanl Fees - 981
For covered services service"981"
delivered to members of product "PPO"
the allowed fee is 70 % of the billed amount

for all other: the allowed fee is 70.00 % of the billed amount